

The collaborative method

A strategy for improving Australian general practice



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BACKGROUND The United Kingdom National Primary Care Collaborative (NPCC) is said to be the largest health service improvement project in the world. The 2000 practices participating serve 11.5 million patients throughout the UK. Improvements such as a 60% reduction in waiting times to see a general practitioner and a four-fold reduction in coronary heart disease mortality have drawn the attention of policy makers in Australia. In 2003, I accompanied a group of Australians to Manchester in the UK to participate in an international training course in collaboratives hosted by the NPCC. The Australian government has recently called for tenders to run the Australian Primary Care Collaborative (APCC) program.

OBJECTIVE To describe the NPCC and discuss how the methodology could be adapted and applied to Australia.

DISCUSSION The Australian primary health care system faces challenges in application of evidence to patient care. Collaborative methodology warrants consideration to address these. Differences including distance, business issues, remuneration mechanisms, infrastructure deficiencies and clinician cynicism present challenges in adaptation and application to Australia. Given adequate support, an APCC could empower general practices to continue to make improvements in many areas of activity.

There is an international effort to improve the application of what is known to work in patient care to the patients who need it most.¹ Two disciplines are working on the problem, particularly:

- the academic research community – provides high quality, reliable research evidence of effective interventions and has itself proven it is failing to achieve implementation of these research findings in primary care², and
- the ‘quality improvement movement’ – provides effective methods of changing individual behaviour and systems to provide better outcomes; makes compromises in the interests of effectiveness which lay it open to criticism from proponents of the first discipline with regard to its intervention design and measurement.

It would seem ideal to couple the two for maximum complementary effect.

The National Primary Care Collaborative

The National Primary Care Collaborative (NPCC) has been implemented throughout the United Kingdom by the National Primary Care Development Team (NPDT). It is the vision of Sir John Oldham, a general practitioner from Glossop in Derbyshire, who learnt about quality improvement at the Institute for Health Improvement (IHI) in Boston in the United States. He has modified and applied the IHI’s ‘breakthrough’ methodology³ to UK primary care. Results attributed to the NPCC include:

- engagement with 11.5 million patients through 2000 participating practices⁴
- a 60% reduction in waiting time to see participating GPs⁴
- a four-fold reduction of mortality from existing coronary heart disease in participating practices compared with others⁴, and
- multiple reductions in waits and delays

between primary and secondary care.

Immediate topics for improvement have been:

- improved appointment and staffing organisation to improve access of patients to their primary care providers (using ‘advanced access’ concepts)^{5,6}
- the care of patients with existing coronary heart disease, and
- access of patients to secondary referral in the health system.

These choices of topic were very attractive to those who might fund the collaborative as well as to primary care providers. In addition to the immediate clinical goals, the strategic intent of the NPDT is to increase capacity and capability for quality improvement in primary care.

What is a ‘collaborative’?

A collaborative is a strategy for achieving rapid improvement in clinical outcomes through bringing providers together. This is achieved through

Table 1. The NPDT collaborative model

- Expert reference committee consisting of collaborative staff (to organise), acknowledged experts (to provide the evidence base) and successful quality improvers in the field (to provide practical knowledge) determine ‘change concepts’ for the collaborative. This process is allocated 1 day only
- Orientation workshop for prospective participants. Introduces the topic, the collaborative method and the team, and asks for commitment to the collaborative. Participants return to practice and do preliminary measurements
- First learning workshop introduces concepts such as process mapping and plan/do/study/act (PDSA) cycles (Figure 1) to participating practices together with success stories. Sets an 8 day challenge to produce and return the first PDSA. Typically the collaborative will have 300 participants from 100 practices at learning workshops
- Action period. PDSA cycles and process design with reporting. Practices are supported to start making changes and report using the methods and measures they have learnt. Global measures collected by the NPDT record progress of the collaborative overall
- Second learning workshop. Sharing of successful strategies between practices. Encourage participants to be involved in spread to nonparticipating practices. Share overall results of the collaborative so far
- Action period. PDSA cycles and process design with reporting. More practices successfully implement change as they learn from the example of others and share strategies
- Third learning workshop. Sharing of success of the collaborative. Share success of spread. Celebrate

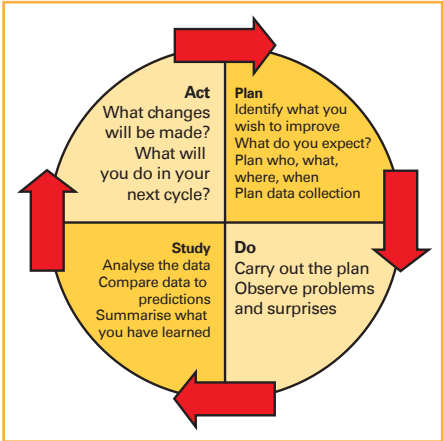


Figure 1. The PDSA cycle¹

running a series of workshops separated by action periods (Table 1). Clinicians share and learn ways of improving their organisations in order to achieve an identified goal. A hypothetical collaborative is demonstrated in Figure 2.

Spread

Central to the collaborative strategy is a conscious and explicit plan to spread the improvements to all practices. The strategy is

based on established principles of change psychology and the work of Rogers on the diffusion of change.⁷ The latter recognises that change tends to spread through communities in a predictable way. The NPDT has sought to speed this process by concentrating on early adopters and early majority in the primary care community. Specifically they aimed to reach 20% of practices in 20% of primary care trusts (similar to Australian divisions of general practice) within the first 2 years of the collaborative. Rogers’ work would suggest that once this proportion has adopted the change, a ‘tipping point’ is reached and the innovation will spread quickly to the majority of primary care trusts and the practices they serve.

What are the strengths of the NPCC?

The keys to success seem to be:

- the mutual support, creativity and enthusiasm engendered by bringing practices and their staffs together to collaborate on solving clinical and organisational problems
- effective skilling of participants in

- methods for improving their organisations (eg. process mapping and PDSA cycles)
- strong local support of practices from trained quality improvement project managers who are in turn supported by the NPDT
- adequate financial resources
- wise choice of topics
- a strong commitment fostered through personal relationships with support teams, and
- strong and effective leadership.

There are obvious practical barriers to evaluating collaborative methodology by randomised controlled trials,⁸ leaving the process vulnerable to the scepticism of research scientists. On a micro level, the short sharp PDSA cycles (Table 2) rely on measures of improvement that might be considered ‘soft’. They do have the benefit of actually being ‘do-able’ in clinical practice unlike many rigorously designed research supported interventions.

A rigorous economic evaluation of the NPDT is not available. Establishing and running a collaborative on the scale of the NPDT is expensive, raising issues of the appropriate scale for Australia as well as opportunity cost.

Adapting/implementing the method in Australia

An APCC offers an opportunity to address some important deficiencies in the application of evidence to patient care. Perhaps more importantly it also provides a context for the acquisition of quality improvement skills by Australian general practitioners. With adequate support to permit maintenance of this enhanced capacity, a resource to enable future improvements to patient care may be created. The 2003 Australian government budget set aside \$16.4 million over 4 years for general practices to implement collaborative methods for the prevention of chronic disease and illness. The impact of such an investment should be very large.

Discussions with colleagues suggest practice re-organisation around demand and capacity (access) would be a popular topic in rural and urban fringe areas. In ‘well doctored’ areas, GPs might be interested in better matching of demand and capacity to improve patient experience and doctor quality of life.

Context
The Western Mountains Division of General Practice (WMDGP) decides to do something about the constant consumer complaints about lack of access to GPs in their urban fringe area. Their strategy is to run a collaborative in 'advanced access' open to all 34 practices within the division. They secure funding under the division innovations grant process. A project officer is employed to study the collaborative model and implement the project.
Implementation
An expert committee is convened which meets one Saturday in March. Attending are the project officer, a leading local GP who will act as chair of the collaborative, the chair of the division, two academics from interstate who are experts in the theory of practice organisation, two GPs who have implemented 'advanced access' in their own practices (one from a neighbouring division and one from interstate). The GPs present briefly on what they did in their practices and the experts comment on the theoretical aspects. By the end of the day they have decided on the access model they will be recommending and the measurements they will ask the participating practices to make to decide whether or not improvement is occurring. The project officer takes all this away and writes it up in a booklet, 'A new deal for doctors and patients: the WMDGP access collaborative'.
Orientation – April
The chair of the collaborative welcomes the representatives of the 25 practices who have responded to the invitation to attend the workshop. It is explained that if they choose to participate in the collaborative they will be working together to improve the efficiency of their appointment scheduling. The GPs on the reference committee explain what they did and how it affected their patients' satisfaction and their own lifestyle. The chair invites all attendees to join, provided they are willing to commit to 3 full day workshops over 9 months and to collect the global data measures that will measure the success or failure of the collaborative. Some of the local GPs are angry that the government appears to be just trying to make them work harder to see more patients, rather than finding more doctors to work in the western mountains. A lot of complaints are voiced and at least two practices walk out. In the end, 12 practices commit to participate. These practices are asked to measure the demand for their appointments, the number of appointments they offer (their capacity) and the average wait to see their GPs.
First learning workshop – May
A month later a GP and a staff member from each practice attend a full day workshop at a local resort. The concepts of quality improvement, the collaborative method and 'advanced access' are explained in more detail with examples of successful change described. Process mapping and PDSA cycles are explained in more detail. Data collection is re-emphasised. After lunch the group breaks into smaller groups to look at the demand and capacity measurements they have already taken. Some realise that, although their waiting time is 2 weeks, in fact week to week demand and capacity are almost in balance. The problem is that they are carrying a backlog. Others see the standard 15 minute appointment doesn't meet the needs of all patients. They plan PDSA cycles together that might increase the capacity of the practice to see patients. One group decides to try 5 minute phone consultations for which the patients need to pay \$15 by credit card over the phone. Another decides to trial an hour of 6 minute consultations by one doctor each day for repeats and simple problems. Another realises that phone calls for repeats and referrals are blocking a lot of receptionist time. They decide to trial standardised email and fax access for these things.
Action period 1
The practices were challenged to submit a written PDSA cycle within 8 days of the first learning workshop. Nine practices managed this. The project officer visits each practice helping them with the concepts, data collection and ideas. Each month the practice reports on the average wait to see their GPs.
Learning workshop 2 – August
The project officer presents on PDSAs reported and on the change in average waiting time across all practices. This has dropped from an average 12 days to an average of 8 days in the 3 months since the first learning workshop. Each practice presents what they did and how it went: successes and failures. One practice has managed to go from a 2 week wait to 2 days, partly through better use of their practice nurse. They describe the PDSAs that made the biggest difference. Two practices have not carried out a PDSA. While a little shamefaced, the teams from these practices get good tips from some of the others who have overcome similar problems to theirs.
Second action period
For another 3 months the practices continue reporting their wait times and trialling different methods of shaping their demand or increasing their capacity. By now, seven of the practices have moved to advanced access in which demand and capacity are well balanced and the back log has been worked down. The project officer continues to visit and help those who are finding things difficult. One practice in particular is so overwhelmed by demand that they are nowhere near meeting it.
Third learning workshop – November
The project officer reports that the average waiting time across the 12 practices is now down to 5 days (a 60% reduction). Some practices report that patients are learning they can ring on the day and get an appointment. They do not book so far in advance and so there are less 'DNAs' (did not attend) which means increased capacity. Staff are finding they can nearly always grant appointments and there is less searching for future 'available's. There is no need to reserve appointments in advance and no rush at 9.00 am for the few reserved appointments. There is less 'gaming' the system (eg. staff relatives or favourites get in easily). Phone calls for appointments are briefer. Staff members are happier and have more time for other tasks. Doctors are finding they are finishing on time and are earning more money. The constant need to catch up and squeeze people in has been alleviated and their days are less stressed. Other practices in the division are hearing about the changes that are going on. A number have asked to join the collaborative. This workshop ends with thanks from the chair for all the hard work that has gone into the collaborative, congratulations to all for the results, and a family barbecue celebration.
Spread
The division decides to run another 'wave' of the collaborative. This time the practices in the first wave provide the examples and run the small groups on PDSA cycles and process mapping. The second wave is even more successful because the examples, the drivers and the strategies are local.

Figure 2. A hypothetical collaborative

Table 2. A sample PDSA cycle carried out after the Manchester workshop

Plan

To reduce my lateness during consulting sessions. I will give each patient a printed card outlining how long the appointment is and why it is important for us all to stick to time. I will measure how late I run before using the card and after. I will ask about patient satisfaction with the card

Do

Receptionists gave a card to each patient which was read and returned. Receptionists also gave the satisfaction questionnaire to a sample of patients after the consultation in each session

Study

My average lateness over 3 sessions reduced by half and patients were highly satisfied with the card and the fact that I was more on time

Act

We will continue to use the card and some colleagues in the practice are interested in using it. Next I might try a buzzer (Plan)

Many aspects of the NPCC – such as the psychology of change, the innovation diffusion curve, PDSA cycles, and process design – are generic concepts that apply anywhere in the world. However, Australia has unique challenges in their application. The National Institute of Clinical Studies has experience with successfully implementing a collaborative in emergency care on a national basis in the Australian context.

Challenges for an APCC

Distance

While many general practices are concentrated in urban areas, others are also thinly spread over great distances. Collaboratives, by definition, require people to be brought together to learn skills and to share ideas and successes. This will be an expensive and complex process to implement in Australia.

The immediate dilemma raised is whether to take a national approach such as the NPDT or to adopt other strategies such as state based collaboratives or commence with a 'pilot' in one area and then spread out.

Population workforce mismatch

There are large areas that are under supplied with GPs. Practices in these areas face different issues to those practising in some city areas where there is a relative over supply. Practices may be very stressed with little energy or capacity to participate in a collaborative.

Alienation

Australian GPs are suspicious of government motivations in general practice reform. These concerns will need to be assuaged if a collaborative is to succeed in Australia. Ownership of the process by the profession would help.

Business issues

Australian GPs operate in a competitive environment. Patients can 'vote with their feet' by leaving a practice they are unsatisfied with or by attending several practices concurrently. Over many years this has led Australian general practice to have a sensitive consumer focus. Choosing one practice in a locality to participate in an initiative such as a collaborative may have a positive or negative impact on their ability to compete with other local practices. There is a risk of alienating participating practices or their competition.

Patient mobility

In the UK, patients are enrolled with one practice. Australian patients are not tied to one practice, so population based interventions such as the coronary heart disease initiatives of the NPDT will be more difficult to initiate and evaluate.

Fee for service

As distinct to the UK, the more patients Australian GPs see the more money we earn. Initiatives that manage patient demand by decreasing it are attractive in the UK. They will be difficult to sell in Australia. In areas of oversupply a GP's interest is likely to be

minimal. Harried GPs on the urban fringe or in rural areas will be keen to manage demand and capacity. In all areas access initiatives should be designed to improve viability of practices (ie. to make them more profitable). Improved quality of life for the doctor through more sensible hours and better scheduling will also be attractive if the necessary first step can be achieved.

Infrastructure funding

United Kingdom general practices are more likely to function as primary care teams with several staff members other than doctors. Australian practices are much less resourced with staff usually paid from fee for service earnings rather than direct infrastructure grants. There tend to be fewer trained staff members in general practices to spend time on quality improvement. If GPs are to commit resources to this activity there will need to be convincing financial arguments made.

Information technology systems

General practice software in Australia is a commercial product, deeply embedded in business systems and apparently lacking in some aspects of measurement that underpin quality improvement. Some software does not easily allow the required searching of practice populations by disease or treatment parameters.

Connectivity

Most practices are computerised but only for specific functions such as billing, prescribing, downloading of results (by direct phone link rather than via internet) and increasingly clinical records. For urban practices (the majority) this does not usually include internet connection to the doctor's desk or broadband connection for the practice. This will exacerbate distance issues in implementing a collaborative.

Conclusion

The training undertaken in Manchester has educated a number of Australians in the 'nuts and bolts' of running the NPCC. Anecdotally, GPs who hear about the improvements made through the NPCC are enthused about the possibility of applying the principles to their local

situation. It is the appointment scheduling improvements known as 'advanced access' that excite them most. People running general practices in Australia will enthusiastically embrace training in how to better organise their businesses. They are interested in clinical outcomes, but these must be underpinned by financial and lifestyle outcomes. The NPCC is a very successful example of improvement that has worked in a system that is similar but different from ours. If the principles learnt there can be effectively applied in Australia there is potential to greatly improve the health of general practice in Australia and more importantly the health of Australians.

Further information

The National Primary Care Development Team: www.npdt.org
The National Institute of Clinical Studies: www.nicsl.com.au

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